Policy Analysis

Cato Institute Policy Analysis No. 224: SSI: The Black Hole of the Welfare State

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Executive Summary

Congress is finally reforming the Supplemental Security Income (SSI) program. Unfortunately, the reforms currently under consideration fall far short of the dramatic overhaul that open-ended entitlement program needs.

SSI is one of the fastest growing welfare programs in the federal budget, and its costs are projected to accelerate by another 60 percent by 2000. SSI was originally designed to provide a safety net for low-income senior citizens, but it is now experiencing spectacular growth in recently eligible population groups, including drug addicts, the mentally ill, immigrants, and children. Government projections indicate that between 1990 and 2000 the number of immigrants on SSI will have grown fivefold and the number of drug addicts and alcoholics eightfold.

Many of the House Republican proposals, such as ending SSI for immigrants, are sensible, but they are insufficient to cap SSI's skyrocketing costs. Some of the SSI reforms recommended in this study include the following: (1) terminating automatic cost-of-living increases for SSI, (2) eliminating lump-sum payments to SSI recipients, (3) ending all childhood disability benefits, (4) creating an enrollment cap, (5) scaling back mental impairment benefits, and (6) ultimately privatizing disability insurance.

Introduction

Over the past several years, the Supplemental Security Income program (SSI) has been plagued by scandal and exploding costs for taxpayers. Enacted 20 years ago primarily to provide a supplement to Social Security retirement benefits for low-income seniors, SSI has experienced phenomenal, unanticipated growth in program enrollment and dollar outlays. Currently, populations that were once marginal to the primary mission of SSI--such as drug addicts, alcoholics, children, and immigrants--are swelling the ranks of SSI, and their numbers are expected to increase (Figure 1). Meanwhile, the percentage of aged Americans on the rolls has been dropping (Figure 2). SSI is a troubling case study in how federal entitlements continually expand beyond their original mission. Today, SSI is one of Washington's primary fiscal black holes.

The combined federal expenditures of SSI and its sister program, Disability Insurance (DI), are now $55.3 billion.[1] Disability has become the fourth largest area of federal entitlement spending after Social Security retirement, Medicare, and Medicaid.[2]

And SSI's costs have just begun to escalate. The Clinton budget for fiscal year 1996 projects that federal expenditures for SSI alone will grow by over 60 percent by FY 2000.[3] That will make SSI larger than Aid to Families with Dependent Children (AFDC), food stamps, subsidized housing, the earned income tax credit, and all other forms of public assistance except Medicaid.[4]

In August 1994 a package of reforms was enacted to deal with some of the program's most highly publicized trouble spots. However, those reforms as a group merely tinker at the edges of SSI and leave basically intact a program that is fundamentally flawed. Without further serious reform that challenges the open-ended nature of the SSI program, there is no hope for curtailing SSI's skyrocketing costs.

Possible reform measures are set forth at the end of this study. They include terminating the SSI program at the federal level and returning to the states the responsibility for providing assistance to low-income aged, blind, and disabled persons. If SSI continues at the federal level, enrollment should be capped and expenditures limited. And children and substance abusers should no longer receive cash assistance. Other federal programs already address the needs of children, and substance abusers should be forced to compete for new drug treatment slots.

Figure 1
Projected Increases in SSI Caseload
[Graph Omitted]

Source: Jane Ross, income security issues director, General Accounting Office, "Supplemental Security Income: Recent Growth in the Rolls Raises Fundamental Program Concerns," Testimony for House Ways and Means Committee, Subcommittee on Human Resources, January 27, 1995.

Figure 2
Number of SSI Recipients by Eligibility Group
[Graph Omitted]

Source: Jane Ross, income security issues director, General Accounting Office, "Supplemental Security Income: Recent Growth in the Rolls Raises Fundamental Program Concerns," Testimony for House Ways and Means Committee, Subcommittee on Human Resources, January 27, 1995.

What Is SSI?

SSI is a welfare program, an open-ended entitlement program for low-income aged, blind, and disabled persons. SSI is administered by a social insurance agency, the Social Security Administration (SSA), because that agency runs a previously established social insurance entitlement program, DI, for disabled workers and their dependents.

SSI and DI were not features of the original Social Security Act of 1935. Although the 1935 act contained several provisions other than Social Security--such as unemployment compensation; aid to the states for health services; cash assistance to the poor, a program now known as AFDC; federal matching grants to the states for public assistance to blind persons; and a temporary program for aged, low-income persons already retired in 1935, funded in conjunction with the states--the act left the job of providing assistance to low-income aged, blind, and disabledpersons primarily to the states. For many years the states funded and ran those "adult assistance programs."

In 1956 the first federal disability benefits program, DI, was enacted and added to the Social Security Act as Title II. DI provides benefits to disabled workers who have substantial past earnings and to their dependents. DI is a social insurance program funded from payroll taxes. DI benefits are not means tested, that is, they are not restricted to people with low incomes. Therefore, disabled workers and their dependents are entitled to DI benefits regardless of the family's net worth.

SSI, which was added to the Social Security Act as Title XVI in 1972, began operating in 1974. SSI is a means- tested cash-assistance welfare program for low-income aged, blind, and disabled persons. SSI made the state adult assistance programs federal to a great degree, although not entirely. Unlike social insurance, SSI is funded from general revenues, not payroll taxes. A person's entitlement to cash assistance under SSI does not depend on the previous payment of payroll taxes.

Although SSA runs both SSI and DI, disability determinations are still made at the state level. The methodology for disability determination is essentially the same for both programs, although SSI claimants often present less evidence to prove disability than do DI claimants. It is possible for one to receive benefits under both programs at the same

time. In fact, dual claims rose 66 percent from 1990 to 1993.[5] Now approximately 1.3 million people receive both SSI and DI benefits concurrently.[6]

The SSI and DI statutes contain an ostensibly strict definition of disability. The applicant must be unable "to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."[7] That definition purports to include only long-term, total disability.

Although disabled persons now outnumber seniors on SSI, the SSI program was sold to the country in 1972 as an incremental extension of the Social Security retirement system. Some seniors were finding it hard to get by on their modest Social Security payments. The intent of SSI was to supple- ment their retirement benefits without treating them like welfare recipients, a sentiment much in keeping with the then prevailing War on Poverty mentality. The Senate Finance Committee report at the time of SSI's inception de- clared that federal assistance would "provide a positive assurance that the Nation's aged, blind, and disabled people would no longer have to subsist on below-poverty-level incomes."[8]

Despite the focus on adult assistance, disabled children were included in SSI, apparently without much discussion or examination of what the costs might be.

Why SSI Keeps Growing and Growing

In just the past six years, SSI's costs have roughly doubled. As Table 1 shows, in 1988 there were 4.46 million SSI recipients, and federal payments totaled $10.7 billion. By 1993 the program had grown to nearly 6 million recipients receiving federal payments of $20.7 billion.

SSI was originally sold on the basis of primarily helping the aged, but nearly two-thirds of the recipients today are blind or disabled persons under age 65.[9] Although the AFDC program generates the most public outrage of any cash-assistance program, SSI is actually more generous and more costly to the taxpayer. The maximum monthly federal SSI payment in 1995 is $458 for singles and $687 for couples, whereas the average monthly benefit for an AFDC family was $373 in 1993.(10) Federal outlays for AFDC were $12.27 billion in 1993, versus $20.7 billion for SSI that same year.(11) Moreover, most states supplement SSI monthly benefits with state funds. In addition, an SSI award makes program recipients eligible for food stamps and Medicaid in most states. Hence, SSI indirectly swells the ranks and stretches the budgets of other public assistance programs as well.

Still more federal money flows to disabled persons through the DI program and Medicaid. DI paid $34.6 billion to disabled workers and their dependents in 1993.(12) Disabled persons constitute roughly 15 percent of all Medicaid beneficiaries and receive 37 percent ($42 billion in 1992) of all Medicaid program dollars.(13) No one knows precisely why SSI has grown so rapidly and unexpectedly in the past six years. Many factors are probably responsible for the cascade.

Table 1
Growth of SSI Benefits and Recipients
Table 1 omitted

Source: Social Security Administration, 1994 Annual Statistical Supplement, Table 7.A3, p. 285, and Table 7.A4, p. 286. Estimates for 1994 are from the Jane Ross, income security issues director, General Accounting Office, "Supplemental Security Income: Recent Growth in the Rolls Raises Fundamental Program Concerns," Testimony for House Ways and Means Committee, Subcommittee on Human Resources, January 27, 1995.

Liberalization of Eligibility Criteria

Congress, SSA, and the courts have relaxed the rules regarding "disability," thus making it easier to qualify for SSI. For example, the statute was liberalized in 1984 with respect to mental impairments, multiple impairments, and subjective complaints of pain.(14) The Supreme Court in Sullivan v. Zebley (1990) gave children more ways to qualify for SSI; the result is a significant boost in enrollment.(15) SSA changed its regulations regarding childhood mental

impairment at about the same time, and, according to the General Accounting Office (GAO), the new regulations account for even more new childhood recipients than did the Zebley case.(16)

Thus, SSI is following the historical pattern of swift expansion of definitions, as observed in earlier disability programs. DI, passed in 1956, was originally limited to workers between the ages of 50 and 65. In 1958 dependents were included in coverage. In 1960 the age restriction was removed. Then in 1965 the definition of disability was expanded so that conditions expected to last only 12 months qualify as permanent disabilities.(17) Table 2 is a list of symptoms that SSA uses to determine whether an applicant is eligible for $458 monthly disability checks for emotional, psychosomatic, and personality disorders.

Courts have a long history of expanding the definition of disability, starting with the government's War Risk Insurance program for World War I veterans. The pattern continued in the 1930s with respect to private disability insurance policies. It was then that courts refused to accept as literal the explicit language in private policies requiring claimants to be "wholly incapacitated before their claims would be honored.(18)

Outreach and Advocacy

Partially in response to congressional mandates, SSA is spending roughly $8 million a year to find new beneficiaries. At the same time, relentless advocacy on the part of professionals and groups that lobby for minorities and the poor has led to increased claims. Outreach is conducted at homeless shelters and through advocacy groups that can locate disabled persons and help bring them onto the rolls.

The Economy

A sharp increase in disability claims followed the 1990 recession. Similar correlations have been observed in other nations between a poorly performing economy and spikes in the number of disability claims.(19) Yet the rolls for SSI have not shrunk during the 1992-94 recovery.

State Cost Shifting

Several states, including Illinois, California, and Michigan (which has terminated general assistance), have taken steps to switch disabled residents from state relief programs to SSI.(20)

Symptoms SSA Uses as Eligibility Criteria
Emotional Disorders Psychosomatic Disorders Personality Disorders
Table ommited

Source: "The Disabling of America," Baltimore Sun, January 22, 1995.

Appeals

Should their claims be denied, claimants can pursue several layers of appeal; 80 percent of appeals are now ultimately successful. Appeals are being launched in record numbers as claimants and their lawyers discover that the door to SSI is seldom permanently shut. For example, law- yers in Pennsylvania run ads declaring, "Social Security is well known for denying meritorious claims that later are approved. . . . Don't let a bureaucrat determine your fu- ture. Keep appealing."(21)

Benefits Indexed

SSI benefits have been indexed to the Consumer Price Index since the program began operation in 1974.

All of those factors combine to vastly expand the number of disability claims and program costs. The number of new claims filed each year for SSI and DI has risen roughly 50 percent, from about 1.5 million annually in the 1980s to 2.4 million in 1992.(22)

SSI: Scams, Scandals, and Incompetence

A spate of media horror stories on the scandals and abuses that appear to pervade the program has finally brought SSI into the public spotlight. For many persons who now receive SSI, the claim of "disability" is highly dubious. Such trouble spots have proliferated in the 1990s, thus casting a long shadow over the entire SSI program.

Drug Addicts and Alcoholics

On February 28, 1992, the Bakersfield Californian ran the following story:

Linda Torrez said she was paid $8,585.82 by taxpayers for being a junkie.

Torrez was arrested last week on charges of possession and use of heroin. During the raid, Bakersfield police found a paper sack with more than $5,000 in it. . . . Torrez . . . produced documentation showing the money was hers via a lump sum payment from . . . Supplemental Security Income. She said she is disabled and due to start receiving monthly benefits.

Her disability: She is a heroin addict. . . .

Addicts or alcoholics must . . . present the Social Security Administration with a . . . payee who is responsible for the benefits.

Torrez told police her monitor was Samuel Mendez. . . . Mendez was arrested the same day as Torrez, also on charges of heroin use and possession.

Since that time, there have been countless similar reports of substance abusers' receiving lump-sum payments of $5,000, $10,000, $25,000, and even $39,000 from SSI.(23) The lump sums are generated because the claims process and resulting appeals drag on for months and even years, and benefits are paid retroactively to the date of application.

The number of drug addicts and alcoholics on SSI who are coded DA&A (drug addicts and alcoholics) in SSA's computers is growing rapidly, from 3,000 in 1983 to more than 101,000 in 1994.(24) In addition to those persons coded DA&A, there are thousands more on SSI with primary or secondary diagnoses of substance abuse who are not coded DA&A for reasons that are not altogether clear. In all, there are an estimated 250,000 substance abusers on SSI and DI; most of them have not been subject to program controls, discussed below.(25) A new law, passed in August 1994 contains many reforms designed to broaden the coverage of program controls and to improve their effectiveness.

Although alcoholism is more often the problem than drug addiction, substance abuse is now an independent basis for a finding of disability if it is deemed to preclude substantial employment. That change in the concept of disability was made in the regulations in 1975 but not fully implemented until later.(26) At present, SSI operates on the philosophy that addiction is an illness and not a result of individual behavior and choices. However, the view that addiction is a disease remains disputed.(27) Also, many health officials agree that even if addiction is a disease, a person retains significant elements of personal choice and personal responsibility. Because addiction is an independent basis for disability, able-bodied substance abusers can receive disability benefits without having to show liver damage or any other physical manifestation of their addiction.

Technically, substance abusers are subject to program controls. Abusers who are coded DA&A must have a "representative payee," a person whom the abuser designates to receive the benefit checks. The payee is supposed to dispense the money to the abuser in a responsible manner so that it will not be used to purchase drugs or alcohol. But many payees are simply friends or family members who knowingly turn over all the money to the addict. Even worse, many payees have turned out to be drug addicts themselves. Other payees have addresses at liquor stores, bars, and check-cashing establishments in high-drug-use areas. Sen. William Cohen (R-Maine) recently complained about "a case in Denver where a liquor store owner is getting $160,000 a year to, in effect, run a tab for the recipients."(28) No background checks are performed on payees.

Abusers coded DA&A must also participate in treatment when "available and appropriate." However, the Department

of Health and Human Services (HHS), Office of Inspector General found in 1991 that SSA did not know the treatment status of 82 percent of DA&As. Of the remaining 18 percent, fewer than half were participating in rehabilitation programs. Those numbers have not changed substantially since then.(29) The mindset of the agency was revealed in 1983 when an SSA official said the agency had never enforced the treatment requirement and considered it largely symbolic.(30)

The inefficacy of program controls has serious adverse consequences. Investigators have determined that as many as 90 percent of SSI substance abusers use their benefits to purchase alcohol and illegal drugs.(31) Drug counselors and social workers confirm that their addicted clients spend SSI money on drugs and alcohol. In San Francisco one addict admitted that he used his monthly SSI benefits to buy "speed" in bulk, which he then repackaged and sold on the street at a profit.(32) Thus, SSI pumps money directly into the drug economy. Tragically, many DA&As die, while on the program, from drug overdose or acute alcohol poisoning.(33)

In its first 20 years of providing disability payments to substance abusers, the SSI program has clearly not worked as Congress intended. Addicts were supposed to receive treatment, be cured, and leave the rolls.(34) Instead, SSI pays substance abusers to stay addicted. Few recoveries have been documented in the entire time that SSI has existed.(35) It is a sad commentary on the virtually complete failure of SSI with respect to substance abusers that the most common way addicts leave the program is by dying.(36)

Childhood Disability

Gaming the childhood disability system has become epidemic. In one recently reported case of SSI abuse in Wisconsin, a father (himself on SSI and DI) coached his daughter to put gum in her hair, to act up in the classroom, and to earn bad grades. SSI eventually added her to the rolls and gave her a lump-sum award of $18,000 retroactive to the date of her application. The family bought a car, furniture, and new clothes and vacationed in Florida. The daughter had a job, but the father warned her "not to take too many hours because it will make us lose your benefits."(37)

In Decatur, Illinois, an elementary school principal told the local newspaper about a mother and her three children who receive $1,736 a month in SSI payments. The children, who are supposedly disabled, go to regular classes and participate in routine physical activities. The principal said that SSI is known on the streets as "crazy money," because you have to act crazy to get it. Applicants even send "ringers" (disabled children who stand in for applicants) to SSI exams.(38)

Teachers now complain that students increasingly and deliberately disrupt class or abuse instructors or classmates to establish and maintain eligibility for SSI benefits. The HHS inspector general has testified that "we have identified some children whose disability and subsequent eligibility is questionable."(39)

Those circumstances may help explain why the childhood disability rolls have expanded. In 1989 there were 296,300 disabled children on SSI, at a cost of $1.2 billion. By the end of 1994 their numbers had more than tripled to almost 900,000, at an approximate cost of $4.5 billion.(40) The increase is partly attributable to the Supreme Court's decision in Zebley in 1990, which expanded eligibility criteria for children. Before Zebley the disability benefits for children were restricted to certain standard medical impairments. In Zebley the Supreme Court ruled that children, like adults, must be individually assessed to determine whether their overall level of functioning indicates that they are disabled. As a result, all low-income children who do not function at an "age-appropriate" level are eligible for SSI. Zebley forced a review of 450,000 prior cases, and SSI awards are being made in about one- third of them.(41)

New medical standards for childhood mental impairments have produced even more awards than has the Zebley case.(42) Adopted in 1990, the new regulations emphasize nonmedical, functional criteria such as social, communication, and cognitive skills. The new standards also added several syndromes to the listings, including attention deficit hyperactivity disorder, mood disorders, and personality disorders.(43) Some childhood mental impairments have been disputed, such as attention deficit hyperactivity disorder and oppositional defiant disorder.(44) Awards based on disorders broadly termed "behavioral problems" are an increasing percentage of all childhood mental impairment awards, whereas mental retardation is declining as a percentage.(45)

The overall award rate for children--that is, the percentage of applications resulting in awards--has risen from 38 percent before Zebley and the aforementioned mental impairment changes to 56 percent afterwards.(46) In all, nearly half a million children receive SSI as a direct result of the Zebley decision and the changes in mental impairment standards.

Interpreter Fraud

Honest "middlemen" often help people fill out and process application forms for SSI. In May 1993 Hour Bun Khy, a middleman, was arrested in Southern California in a sting operation involving Cambodian immigrants, crooked psychiatrists, and SSI. California State undercover agents, wired for sound, went to Khy's office pretending to need help qualifying for SSI benefits. The Orange County Register reported that Khy told the agents, "I need to teach you how to lie."(47) Khy coached them to tell the government that the Communists killed their families and to pretend to suffer from headaches, depression, and insomnia. "Don't look at anybody," Khy said. "Seem to be sad. . . . You have to say you're sick. . . . You have to know your illness." The next step in the scam was to identify a cooperative psychiatrist who would sign a bogus certificate of mental impairment. Khy would then act as interpreter during the disability determination process in exchange for a portion of the applicants' retroactive lump-sum awards.

Khy was prosecuted for state Medi-Cal fraud, but there have been no federal indictments for such interpreter fraud in Southern California as of this writing. There have been indictments in the state of Washington, and investigators report that the same scam is being worked in immigrant communities in other American cities. There are thousands of suspected cases of interpreter fraud in California alone.

At a congressional hearing in February 1994, witnesses testified that a single dishonest interpreter can generate hundreds of nearly identical bogus claims. For example, all 300 patients at one clinic were diagnosed as "mildly mentally retarded" in boilerplate psychological reports.(48) A consulting psychologist hired by California Medi-Cal authorities concluded that the reports had a "numbing sameness to them."(49)

Immigrants on SSI

There is also concern that the overall number of non-citizens on SSI is growing faster than the rate of immigration. In 1982 there were 127,900 aliens on SSI, constituting 3.3 percent of all SSI recipients. By 1992 the number had grown to 601,430 (10.9 percent of all SSI recipients and 25 percent of aged recipients).(50)

Aliens on SSI are primarily legal immigrants, who follow standard immigration procedures, and refugees. According to the SSA 1994 Annual Statistical Supplement (p. 299), about three-quarters of the aliens on SSI since the program began have been legal immigrants and one-quarter have been refugees. Illegal aliens are not thought to be on SSI in any great numbers, but there have been some cases in which illegal aliens obtained fraudulent Social Security numbers and went on SSI.(51)

Fraud and Corruption

Over the years, scam artists have discovered a multitude of ways to defraud the SSI program. Their methods include filing multiple claims under bogus Social Security numbers, feigning disabilities--sometimes with the help of professionals--and concealing financial assets or a return to work. There are also stories of representative payees' spending program money on themselves after the recipient dies. Fraud appears to be deeply rooted within the culture of the program, as the following examples illustrate:

A California woman was convicted in a jury trial for murdering three of seven SSI beneficiaries found buried in the yard of her boarding house. She had been charged with murdering all seven former boarders, plus two found elsewhere, for their benefits. . . . The woman had impersonated one of the victims in attempting to obtain Dalmane, a drug found in seven bodies. She was sentenced to life imprisonment without possibility of parole.(52)

In New York, a disability recipient was sentenced to . . . prison [and] ordered to make restitution of nearly $300,000. Posing at various times as a psychiatrist, neurologist, attorney and real estate agent, the man filed false medical reports to SSA which resulted in fraudulent SSI and disability benefits for his "patients."(53)

An Iowa man was sentenced to . . . $4,980 restitution for defrauding the SSI program. He applied for benefits in 1984, claiming blindness and unemployment after being hit on the head with a baseball bat during a barroom brawl. He pled guilty to fraud after learning that an investigator made videotapes of him working in a local warehouse unloading semi-tractor trailers, driving a forklift, and reading computer invoices, as well as driving his car on public streets.(54)

The HHS Office of Inspector General compiles statistics on criminal cases of SSI fraud, but the number is essentially unchanged from 1985, despite the fact that the program is now twice as large in dollar terms.(55) That is largely attributable to insufficient monitoring and enforcement.

For example, criminal case referrals have stopped in some places--including in Southern California, the mother lode of interpreter fraud--because of failure on the part of SSA and the HHS Office of Inspector General to investigate.(56)

Mental Impairments

Of the nearly 4 million disabled persons on SSI in 1993, 2.5 million were allegedly mentally disabled.(57) Mental impairment is now the largest category of disability award in both the SSI and the DI programs. In 1993, 29.2 percent of all disabled SSI recipients had mental disorders other than mental retardation, although the percentage presumably includes DA&A substance abusers and children.(58) In 1993, 25.1 percent of all DI beneficiaries were mentally impaired.(59) Mental impairment now accounts for more than half of all new SSI disability awards.(60)

SSA has stated that no supposedly disabling condition, mental or physical, has ever been categorically excluded from being used to support an SSI award.(61) SSA also claims to have no record of how many people receive SSI by virtue of specific conditions, such as anxiety, depression, or compulsive gambling.

One might have expected that the move toward a service economy, the relative decline of workers involved in physical exertion on the job, improved occupational health and safety, and the trend toward more health-conscious lifestyles would have produced a sharp drop in disability claims since the early 1970s. Unfortunately, if a drop actually has occurred, the rising tide of mental impairment has more than made up the difference.

Continuing Disability Reviews

SSI and DI are supposed to be programs for people with permanent disabilities, but the law defines permanent to include conditions expected to last as little as 12 months. It stands to reason that there should be a process for systematically reviewing the caseload to identify recipients whose conditions have improved and who should be removed from the rolls. The integrity of both programs has been jeopardized, however, by the failure of lawmakers until August 1994 to impose such a process on the SSI program and by the failure of SSA to conduct the required number of case reviews in the DI program.

SSA is obligated by law to review a certain number of DI cases each year. GAO reports that SSA has been conducting fewer than half the number of required DI continuing disability reviews (CDRs) since 1987. SSA estimates that more than 2 million CDRs were required, but GAO found that only half that number had been conducted and that the number continues to fall.(62)

A large problem in both programs is that SSA has diverted resources from CDRs and other program-integrity measures to processing the escalating backlog of initial disability claims.(63) The agency's focus is on getting more people into the programs. Because attention is not focused on program integrity, the vast majority of federal disability recipients can, if they wish, look forward to a lifetime of benefits even if their conditions improve.

SSI's Fatal Flaws

To genuinely reform SSI, it is critical to first identify the numerous underlying flaws of the program, some of which are described next.

SSI Discourages Successful Substance Abuse Rehabilitation and Treatment

Even with a 36-month cap, SSI pays substance abusers to stay addicted because cash assistance during those 36 months will be cut off should they recover and return to work. Only those addicts who have the strongest motivation to help themselves ever recover. Therefore, SSI is unlikely ever to produce many recoveries because it encourages addicts to show up for treatment to get the cash, not to be cured.

There Is No Convincing Rationale for Giving Cash Assistance to Disabled Children

Cash assistance for disabled children was supposed to "help them become self-supporting members of our society," according to the House report on the original SSI legislation.(64) The House believed that disabled children have special needs that "are often greater than those of non-disabled children."(65) The Senate disputed that assertion, but the House view prevailed and children were included in SSI.

However, the special needs rationale is counterfeit because families do not have to spend the child's SSI benefits to meet any special needs the child may have. For that reason and others, the HHS inspector general has found that SSI "is not specifically geared toward helping children achieve independence [or] engage in substantial gainful activity as an adult."(66) Moreover, the special needs of low-income disabled children are addressed through other federal and state programs such as Medicaid, Maternal and Child Services block grants, and the provisions for special education in the Americans with Disabilities Act. Ordinary expenses are met through AFDC and food stamps.

The cash-assistance program for disabled children cannot be justified on the same grounds as SSI for adults. The stated rationale for adults is to provide them with a "replacement income." That rationale rarely applies to children because they are not expected to work and thus there is no lost cash income to replace.

SSI Is an Open-Ended Entitlement Program with Limitless Costs

At the heart of SSI lies an inexhaustible engine of growth: the open-ended impairment concept that allows people to file claims for an infinite variety of reasons. No condition is categorically excluded, even if it is self- inflicted, disputed by experts, or invented just yesterday. As if 22 million substance abusers were not a large enough pool of potential applicants, the open-ended impairment concept will allow claims to be made for all supposedly disabling conditions that become fashionable in the future. Obesity, compulsive gambling, and repressed memory phenomenon are just some of the possibilities for new claims on the horizon. There are currently 48 class-action lawsuits pending or threatened with respect to SSA's disability programs.(67)

Particularly worrisome is that SSI has begun to resemble Medicaid--the fastest growing entitlement program. SSI has shown the same unanticipated growth, vulnerability to fraud, relentless advocacy, class-action lawsuits, cost shifting by the states, use of children as a wedge to expand the program, and numerous expansions in eligibility criteria.(68)

SSI Does Not Truly Differentiate between Those Who Can Work and Those Who Cannot

Disability has long been viewed with suspicion and skepticism. Officials in England, as far back as the 15th century, expressed concern that street beggars might be duping the public by pretending to be crippled or blind; manufacturing fake body sores; inflicting lacerations on themselves; or feigning epileptic seizures, dropsy, and leprosy.(69) Fraud is a systemic problem with any public disability program no matter how well constituted.

The 1938 Advisory Council on Social Security stopped short of recommending a disability program, warning that "disability insurance would introduce many administrative problems of great difficulty, and . . . would necessitate intensive and sustained local investigation to prevent abuse."(70)

Proponents of socialized disability programs found a way to overcome that skepticism. According to the 1948 Advisory Council, objective medical testing would sweep away all administrative difficulties and stand "as a safeguard against unjustified claims."(71) The medical model enabled proponents to sell the DI program in 1956 as well as the SSI program in 1972. A supposedly workable definition of "disability" had been found, and the problem of making disability programs politically acceptable was thereby solved through "objective" medical tests.(72)

There is, however, no reliable way to separate the deserving from the undeserving, or to differentiate between those

who can produce income and those who cannot. In the hearings on the 1956 legislation, one doctor asked, "Is the delivery boy who loses both legs totally and permanently disabled? Or is the certifying doctor supposed to point out that he can still run a drill press and probably make more money?"(73)

SSI and DI use medical impairment as a substitute for disability, not because impairment is necessarily disabling but because impairment is supposed to be "objectively" determinable and therefore of unquestionable validity. The intellectual foundations of SSI have pretensions to scientific precision where no such precision exists.

There is no necessary connection between medical impairment and inability to work. Examples abound of people with medical impairments who produce income and succeed in the workplace. Jobs for blind persons are commonplace, and so are jobs for those who are deaf (just ask the National Center for Deaf Entrepreneurs).(74) Many addicts and alcoholics hold jobs.(75) Lawyers in wheelchairs or with special hearing equipment or guide dogs are everyday sights in courthouses. Aided by technology, a quadriplegic who can use only his voice started a computer services company in Illinois, which generated a million dollars in revenue in 1993.(76)

What, then, is a disability? Even if medical testing could determine disability, subjective judgments would still affect the process. Studies show a lack of uniformity in the way doctors interpret x-rays. Many conditions are diagnosed on the basis of a minimum number of listed characteristics or of conventions about the meaning of numerical values of medical tests. Still other diagnoses rely on patients' cooperation, such as when they are asked to "inhale and exhale with maximum effort."(77) Mental health diagnoses are subjective as well and are established on the basis of a minimum number of listed characteristics.(78)

In sum, the determination of disability often hinges on a subjective judgment.(79) SSA officials conceded this in 1994: "Presently, there are no generally accepted measurement criteria for determining an individual's ability to function in relation to work-related activities."(80) That is tantamount to admitting that the emperor has no clothes.(81)

The truth--that there is no reliable way to separate the deserving from the undeserving--was lost in the passage of disability programs in this country, but the truth can no longer be denied. Currently, SSI uses a definition of disability that is fluid and expands under pressure. Predictable and relentless expansion of the eligibility criteria allows more and more people to qualify as disabled as time goes on. SSA is pursuing a new methodology, which it does not claim will be objective or scientifically precise, that will measure disability only "as objectively as possible."(82) Thus, well-intentioned proposals to fix SSI by tightening the definition of disability seem doomed to fail.(83) SSA's new approach brings us no closer to being able to determine who can work and who cannot.

Recent Congressional Reforms

There are many who want to expand SSI, but negative publicity in recent years has caused the momentum to shift toward proposals to reduce program abuses.(84) In August 1994 Congress passed and President Clinton signed into law several SSI reforms that enjoy broad bipartisan support.(85) Most of the reforms took effect in February 1995. They attempt to deal with some of the more notorious problems that have arisen in the SSI program.

Drug Addicts and Alcoholics

The August 1994 law imposes a lifetime cap of 36 months on recipients whose substance abuse is material to their disability. Nothing prevents substance abusers from returning to the rolls as mentally impaired after the 36-month cap.(86) That loophole looms as a real prospect because it is undisputed that substance abuse can induce brain chemistry changes and, furthermore, that many substance abusers have mental problems.(87) Substance abusers who are on the rolls by reason of mental impairment are not necessarily subject to the payee and treatment requirements.

The reforms carry a stiff price tag, supposedly $354 million by 1996, but an internal SSA draft report puts the cost as high as $4 billion by the end of 1999.(88) The expense alone should lead lawmakers to pursue other avenues of reform.

Childhood Disability

The August 1994 law requires SSA, in the next three fiscal years, to reevaluate the eligibility of at least one-third of all

SSI children who reach the age of 18. The law also establishes the Commission on Childhood Disability to study, among other matters, the definition of disability as it relates to children under the age of 18.

Continuing Disability Reviews

The August 1994 law requires SSA to conduct a minimum of 100,000 reviews of SSI cases in each of the next three years.

Interpreter Fraud and SSI Abuse

The August 1994 law contains three major provisions designed to fight fraud and abuse in the SSI program:

1. stricter control of translators,

2. tougher criminal and civil penalties for SSI fraud,

3. a requirement that SSA redetermine eligibility in cases of suspected SSI fraud.

Given SSA's sorry record of disinterest and inaction thus far on fraud and program-integrity issues, it remains to be seen just how effective the new fraud provisions will be.

Flaws Remain

Though well-intended, the reforms contained in the August 1994 law are a disappointment. They are incremental and merely tinker at the edges, leaving intact a program that is fundamentally flawed. Two examples underscore just how narrow the scope of the reform package really is. First, a proposal to study the reasons disability costs are exploding was scrubbed in the House-Senate conference.(89) Second, the Commission on Childhood Disability will not be studying whether a cash benefit program for disabled children makes any sense in the first place, which is the real question about that part of the program.

Toward Real Reform

At the time of this writing, more substantial reforms of the SSI program are working their way through the committee process in the House. The following ideas have been under consideration:

* Putting SSI under a flexible ceiling allowing for inflation and growth in the poverty population.

* Specifying a fixed amount of money and sending SSI to the states as a block grant.

* Terminating SSI eligibility of noncitizens and drug addicts.

* Limiting eligibility of children, restricting cash benefits to only preventing institutionalization, and providing services by way of block grants to the rest.

Those are meaningful reforms, unlike the reforms of August 1994. However, there are still other reforms, not currently under consideration, that should be implemented.

Terminate Automatic Cost-of-Living Adjustments

Congress should have to vote on every proposed increase in benefits. All increases should be subject to the pay-as-you-go requirements of the Budget Enforcement Act, meaning they have to be paid for by cuts in other mandatory spending or by explicitly voting for a tax increase.

Eliminate Lump-Sum Payments

Congress should change the SSI laws to eliminate the large payments generated by the delay between initial

application and approval of a claim. Such retroactive lump-sum payments are a magnet that draws people to the SSI program. Those payments also lead to fraudulent and abusive use of taxpayer funds.

End Childhood Disability Benefits

Rep. Nick Smith (R-Mich.) had a bill in the last Congress to eliminate children under the age of 16 from SSI altogether on the grounds that they do not need replacement incomes.(90) Smith's bill to terminate SSI for children should be adopted because no one has been able to supply a convincing rationale for giving no-strings cash assistance to low-income disabled children.

Terminate SSI for Drug Addicts and Alcoholics

In 1972 the Senate wanted to place substance abusers in a separate program. Congress should end the DA&A program and assist substance abusers through existing state and federal substance abuse programs. Such a move would stop putting cash into the hands of addicts.

Create an Enrollment Cap for SSI

For aged, blind, and disabled persons, a budget should be set and the fixed dollar amount translated into a finite number of beneficiaries. That is, the entitlement program should cease to be open-ended. The initial number of beneficiaries could equal the current number of beneficiaries, to make the proposal more politically acceptable.

Scale Back Mental Impairment Benefits

The 1984 liberalizations regarding mental impairment should be repealed. A commission should be established to examine all claimed mental disorders, to study their effect on ability to work, and to recommend categorical exclusions of all purported diagnoses that cannot plausibly preclude employment.

End Federally Funded Outreach and Expand CDR

SSA should devote its resources to identifying and prosecuting fraud. Congress should declare a moratorium or at least cut back on outreach and require SSA to spend what is currently outreach money on CDRs and investigation of fraud instead.

Clamp Down on Fraud and Abuse

The August 1994 reforms contain significant new provisions dealing with SSI fraud and abuse, including interpreter fraud. But SSI has a long way to go before it even approaches state-of-the-art in fraud control. As they are in so many other matters, the states are ahead in that area. Here are some suggestions based on or inspired by ideas in use or being considered at the state level:

* "One strike and you're off." No law appears to bar people convicted of criminal SSI fraud from receiving SSI or other government benefits again in the future. But such a law is needed to permanently disqualify adults who commit an intentional program violation from ever again receiving aid under SSI or any other federal assistance program. The lifetime disqualification should take place on the first violation, to best deter SSI fraud.

* Early fraud detection. SSI eligibility workers should refer suspicious applications to fraud investigators before granting aid. Fraud investigators should use a variety of techniques, including surveillance, to determine whether the applicant's claim is fraudulent. Investigators should be stationed in field offices to detect fraud during the disability evaluation process. Early detection is the most cost-effective anti-fraud program ever implemented in California.

Ultimately Privatize Disability Insurance

Proposals abound for privatizing Social Security retirement in whole or in part.(91) Such proposals generally advocate a privately administered system of forced savings for retirement. The DI program should be privatized and

incorporated into whatever "super individual retirement account" or other proposal for privatizing Social Security retirement is adopted.

The need for a government-administered disability insurance program has never been established and is particularly questionable given that a market for private disability insurance already exists. Under an opt-out approach to DI, many more Americans would be in the private market, which would summon forth an even greater variety of disability insurance options from private insurers. Indeed, a wide range is currently available. The most expansive and expensive policies cannot be canceled and have fixed premiums.

High-cost policies provide benefits if workers are unable to engage in their current occupation, whereas low-cost policies require that workers be unable to work in any occupation before benefits are paid to them. Policies also differ on types of impairments covered, waiting periods, deductibles, cost-of-iving adjustments, and other factors. Corporations also offer group policies. Thus, an opt-out option from DI would allow individuals far more choices than does the existing uniform governmental system.

Another virtue of private insurance is that, unlike DI, benefit costs are forced into line with policy premiums. Private insurers have a financial interest in controlling costs. A private insurance system, with strong cost-containment features, would save workers money through lower premiums than are now paid through the payroll tax.

Conclusion

Disability has become the back door of the welfare state, and that back door remains wide open. SSI operates without limits. There is no limit to the number of people who can be enrolled, no limit to the amount of money that can be spent, no limit to the number of impairments that can qualify a person for disability benefits, and no limit to the number of considerations that can inform the inherently subjective disability determination process. The program was conceived at a time when a war without limits was declared on poverty. That philosophy has turned the SSI program into a black hole.

Notes

[1] Social Security Administration, Social Security Bulletin: 1994 Annual Statistical Supplement, pp. 158, 282. Cited hereafter as Social Security Administration, 1994 Annual Statistical Supplement.

[2] David Koitz and Geoffrey Kollmann, "Status of the Social Security Administration's Disability Programs," Congressional Research Service, April 7, 1994, p. 1.

[3] Fiscal Year 1996 Budget of the United States Government: Analytical Perspectives, Table 62, p. 88.

[4] Ibid., pp. 8789; and Carolyn L. Weaver, "Welfare Reform Is Likely to Leave This Monster Intact," Wall Street Journal, April 6, 1994.

[5] Koitz and Kollmann, p. 3.

[6] Tom Margenau, Social Security Administration public relations officer, Interview with author, November 15, 1994.

[7] SI, 42 U.S.C. 1382c(a)(3)(A); and DI, 42 U.S.C. 423(d)- (1)(A).

[8] Quoted in U.S. Department of Health and Human Services, Office of Inspector General, "SSI Overview: Program Origins 19691973," OEI099101330, March 1992, p. 4.

[9] Ibid., p. 282.

[10] Spencer Rich, "Social Security Set to Increase 2.8% in 1995," Washington Post, October 15, 1994; and U.S. House of Representatives, Committee on Ways and Means, 1994 Green BookOverview of Entitlement Programs (Washington: Government Printing Office, July 15, 1994), Table 101, p. 325.

[11] Ibid.

[12] Social Security Administration, 1994 Annual Statistical Supplement, Table 4.A6, p. 166.

[13] Dan Morgan, "When Long Term Means Lifetime: Disabled Patients Account for Large Portion of Medicaid Costs," Washington Post, February 1, 1994.

[14] General Accounting Office, "Social Security: Disability Rolls Keep Growing, While Explanations Remain Elusive," GAO/HEHS9434, February 1994, p. 21.

[15] Sullivan v. Zebley, 110 S.Ct. 885 (1990); and General Accounting Office, "Rapid Rise in Children on SSI Disability Rolls Follows New Regulations," GAO/HEHS94225, September 1994, p. 2.

[16] Ibid.

[17] Deborah Stone, The Disabled State (Philadelphia: Temple University Press, 1984), pp. 7178. Some of the expansions of the disability concept have occurred by stealth. For example, Congress voted in 1954 for a "disability freeze," which excused disabled persons from paying Social Security taxes without losing their retirement benefits. Embedded in that seemingly innocuous initiative was the establishment of the disability category in federal law. Thus the way was paved for the DI program passed two years later. Ibid. p. 77. A second example came to light in 1994 when Thomas C. Joe, a senior federal welfare official at the time SSI was adopted, admitted that he inserted children's benefits into the proposed SSI legislation as part of his "incremental strategy" to help as many poor people as possible. Bob Woodward and Benjamin Weiser, "Costs Soar for Children's Disability Program: How 26 Words Cost the Taxpayers Billions in New Entitlement Payments," Washington Post, February 4, 1994.

[18] Stone, pp. 7178.

[19] Ibid., pp. 75-76, 143n. 8, 167; Ilene Zeitzer, "Recent European Trends in Disability and Related Programs," Social Security Bulletin, Summer 1994, pp. 21, 22; and National Academy of Social Insurance, Disability Policy Panel, "Rethinking Disability Policy" (preliminary status report), Social Security Bulletin, Summer 1994, pp. 56, 58.

[20] See, for example, June Gibbs Brown, inspector general, U.S. Department of Health and Human Services, "SSI Drug Addicts and Alcoholics, Disabled Children, and Interpreter-Fraud," Testimony for Senate Appropriations Committee, Subcommittee on Labor, HHS and Education, May 13, 1994, p. 3. Illinois pays lawyers $1,300 for each person transferred from state relief to SSI. Randy Fitzgerald, "America's Shocking Disability Scam," Reader's Digest, August 1994, p. 105. A University of Michigan study found "a sudden and massive shift to federal disability programs" when Michigan terminated general assistance. Edward Walsh, "A Partisan Agenda for Cutting the Roles of Government, Labor," Washington Post, October 7, 1994.

[21] Koitz and Kollmann, pp. 4, 14, 15; National Academy of Social Insurance, Disability Policy Panel, p. 62 (citing a significant increase in the number of claims appealed and an increase in the likelihood a claim will be allowed on appeal).

[22] General Accounting Office, "Social Security: Increasing Number of Disability Claims and Deteriorating Service," GAO/HRD 9411, November 1993, p. 10.

[23] Floyd Brown, assistant director, San Joaquin County Drug Program Services, Stockton, California, Interview with author, March 31, 1993.

[24] Jane L. Ross, income security issues director, General Accounting Office, "Supplemental Security Income: Recent Growth in the Rolls Raises Fundamental Program Concerns," Testimony for House Ways and Means Committee, Subcommittee on Human Resources, January 27, 1995, p. 5.

[25] Sen. William Cohen (RMaine), Congressional Record 103d Cong. 2d sess., March 2, 1994, 140, p. S2197; investigative staff of Senator Cohen, "Tax Dollars Aiding and Abetting Addiction: Social Security Disability and SSI

Cash Benefits to Drug Addicts and Alcoholics," February 7, 1994, p. 10; and June Gibbs Brown, p. 4.

[26] Petition of Sullivan, 904 F.2d 826, 835 (3d Cir. 1990) (the Wilkerson case).

[27] Traynor v. Turnage, 485 U.S. 535, 552 (1988); and Schoolcraft v. Sullivan, 753 F. Supp. 1478, 1488n. 10 (D. Minn. 1991).

[28] Cohen, p. S2197; and Fitzgerald, p. 103.

[29] U.S. Department of Health and Human Services, Office of Inspector General, "Social Security Policies Concerning Drug Addicts and Alcoholics," OEI029000950, July 1991; General Accounting Office, "Social Security: Major Changes Needed for Disability Benefits for Addicts," GAO/HEHS94128, May 1994, p. 6; U.S. Department of Health and Human Services, Office of Inspector General, "SSI Payments to Drug Addicts and Alcoholics: Continued Dependence: An Expanded Analysis," OEI099400071, November 1994, p. 7. In a survey of 400 DA&A recipients, 44 percent indicated that SSA did not inform them of the treatment requirement. U.S. Department of Health and Human Services, Office of Inspector General, "Requirements for Drug Addicts and Alcoholics on SSI," OEI- 02-94-00110, November 1994, pp. ii, 8.

[30] Stone, p. 217n. 29.

[31] See, for example, SRA Technologies of Virginia, 1986 study commissioned by SSA, cited in U.S. Department of Health and Human Services, Office of Inspector General, "Social Security Policies Concerning Drug Addicts and Alcoholics," OEI029000950, July 1991.

[32] Michael Dorgan, "Addicts Feed Habits with U.S. Hand outs," San Jose Mercury News, December 19, 1993.

[33] Floyd Brown (three of his SSI clients had died just within the previous six to eight weeks); Thomas Anderman, Interview with author, in which Anderman described loading many people who were turning gray or blue into ambulances; and idem, Testimony for U.S. House of Representatives Committee on Ways and Means, Subcommittees on Human Resources and Social Security, Joint Hearing on SSIDA&A, February 9, 1994, p. 1. Shelter worker Bob Cote in Denver, Colorado, calls SSI "suicide on the installment plan." Quoted in Fitzgerald, p. 102. See also Michael Rust, "Social Security Scam: Uncle Sam as Enabler," Insight, April 11, 1994, p. 7.

[34] U.S. Department of Health and Human Services, Office of Inspector General, "SSI Payments to Drug Addicts and Alcoholics,: pp. i, 1, 4, 5; General Accounting Office, "Social Security: Major Changes Needed for Disability Benefits for Addicts," GAO/HEHS94128, May 1994, p. 6.

[35] One percent of DA&As in the 19,854case sample left the rolls between 1990 and 1994 because of medical improvement or significant earnings. U.S. Department of Health and Human Services, Office of Inspector General, "SSI Payments to Drug Addicts and Alcoholics," p. 6. Greater success is claimed in pilot projects involving relatively expensive intensive case supervision. John O'Donnell and Jim Haner, "Social Security Crackdown Cost: $300 Million," Baltimore Sun, August 7, 1994. Washington State uses an intensive case management approach that costs an extra $637.50 per recipient per year. The State Division of Alcohol and Substance Abuse has documented an additional 12 recoveries among the 2,703 total cases in the program. Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, "SSI Referral and Monitoring Services in Washington State," August 31, 1994, pp. 1, 8, supplemented through author's interview with Harvey Funai, program official. Recovery is defined as persons' overcoming addiction and, through employment, leaving the SSI rolls. The handful of recoveries documented by all sources does not contradict the conclusion that SSI is not function ing the way Congress envisioned when it enacted SSI in 1972.

[36] U.S. Department of Health and Human Services, Office of Inspector General, "SSI Payments to Drug Addicts and Alcoholics," pp. ii, 6.

[37] Rep. Gerald D. Kleczka (DWis.), Statement before U.S. House of Representatives Committee on Ways and Means, Subcommittee on Human Resources, Oversight Hearing on Supplemental Security Income, October 14, 1993,

p. 1.

[38] Kristi Ruggles, "Principals: SSI Abuses Turn Up in Schools," Decatur Herald & Review, February 20, 1994.

[39] Quoted in June Gibbs Brown, p. 7.

[40] Ross; Social Security Administration, 1994 Annual Statistical Supplement, p. 282; and June Gibbs Brown, p. 5.

[41] Regulations issued in response to the Zebley decision also expanded the eligibility criteria by adding the concept of "functional equivalence" to the medical standards for children. Now children qualify if a medically determinable cause, such as an organ transplant, results in functional limitations equivalent to the functional consequences of any listed impairment. That expansion has resulted in 15,000 awards. General Accounting Office, "Rapid Rise in Children on SSI Disability Rolls Follows New Regulations," pp. 8n. 7, 11n. 12. However, SSA has announced that it will no longer use functional equivalence in childhood cases. Social Security Administration, "Plan for a New Disability Claims Process," September 1994, p. 30.

[42] General Accounting Office, "Rapid Rise in Children on SSI Disability Rolls Follows New Regulations," p. 2.

[43] Ibid., p. 9.

[44] See, for example, Richard Vatz, "Attention Deficit Delirium," Wall Street Journal, July 27, 1994.

[45] General Accounting Office, "Rapid Rise in Children on SSI Disability Rolls Follows New Regulations," Table 2, p. 17.

[46] Ibid., p. 10.

[47] Tracy Weber and Kim Christensen, "The Big Refugee RipOff," Orange County Register, May 16, 1993.

[48] U.S. House of Representatives, staff of Committee on Ways and Means, Subcommittee on Oversight, "Report on Reforms to Address Supplemental Security Income Fraud and Abuse Involving Middlemen," Committee Print, May 12, 1994, pp. 5, 6.

[49] Ibid., p. 5.

[50] Charles Scott, Office of Supplemental Security Income, Social Security Administration, "SSI Payments to Lawfully Resident Aliens," May 1993, pp. 3, 7.

[51] "An Arizona man was investigated for filing a fraudulent SSI claim. Investigation showed that the subject was an illegal alien and that he used a false identity to obtain $8,729 in benefits." U.S. Department of Health and Human Services, Office of Inspector General, "Trends in Social Security Fraud Conviction Cases: Supplemental Security Income Fraud." In response to author's Freedom of Information Act request, June 7, 1994.

[52] U.S. Department of Health and Human Services, Office of Inspector General, "Semiannual Report," October 1, 1993- March 31, 1994, p. 33. Further details of that case are given in U.S. Department of Health and Human Services, Office of Inspector General, "Demographics of Beneficiaries with Representative Payees: SSI Drug Addicts and Alcohol ics," OEI099200857, June 1994, p. 2.

[53] U.S. Department of Health and Human Services, Office of Inspector General, "Semiannual Report," October 1, 1993- March 31, 1994, p. 33.

[54] U.S. Department of Health and Human Services, Office of Inspector General, "Semiannual Report," April 1, 1993-September 30, 1993, p. 47.

[55] U.S. Department of Health and Human Services, Office of Inspector General, "DHHS OIG Statistics: Supplemental Security Income (SSI) Cases," Table FY 1984FY 1993. In response to author's Freedom of Information

Act request, June 7, 1994.

[56] U.S. House of Representatives, staff of Committee on Ways and Means, Subcommittee on Oversight, "Report on Reforms to Address Supplemental Security Income Fraud and Abuse Involving Middlemen," pp. 45.

[57] Ibid., p. 1.

[58] Social Security Administration, 1994 Annual Statistical Supplement, p. 300.

[59] Ibid., p. 219; and U.S. House of Representatives, 1994 Green Book, p. 64. Deinstitutionalization of mental patients has been proffered as an explanation for the increase in mental impairment claims. See National Academy of Social Insurance, Disability Policy Panel, p. 62. However, that explanation is inadequate because it fails to account for the rise in mental impairment claims for DI. DI claimants come from a work setting, not a mental hospital. Therefore, other factors must be operating.

[60] Koitz and Kollmann, p. 11.

[61] "The Social Security Administration does not categorically reject any claimed impairment." Social Security Administration, in response to author's Freedom of Information Act request, April 5, 1994.

[62] General Accounting Office, "Social Security: New Continuing Disability Review Process Could Be Enhanced," GAO-HEHS- 94-118, June 1994, pp. 4, 14.

[63] General Accounting Office, "Social Security: Increasing Number of Disability Claims and Deteriorating Service," GAO/HRD-94-11, November 1993, p. 21; Social Security Administration, Disability Reengineering Project Proposal, 59 Federal Register 18187, 18203, April 15, 1994. More than half of SSA's administrative resources are now devoted to the processing and appeal of initial disability claims. Social Security Administration, "Plan for a New Disability Claim Process," September 1994, p. 4.

[64] Quoted in U.S. Department of Health and Human Services, Office of Inspector General, "Concerns about the Participation of Children with Disabilities in the Supplemental Security Income Program," A-03-94-02602, October 1994, p. 7.

[65] Quoted in June Gibbs Brown, p. 6.

[66] U.S. Department of Health and Human Services, Office of Inspector General, "Concerns about the Participation of Children with Disabilities in the Supplemental Security Income Program," p. 26.

[67] Koitz and Kollmann, p. 20.

[68] Leslie G. Aronovitz, associate director, Health Financing Issues, General Accounting Office, "Medicaid: A Program Highly Vulnerable to Fraud," Testimony before the U.S. House of Representatives Committee on Government Operations, Subcommittee on Human Resources and Intergovernmental Relations, GAO/T-HEHS-94-106, February 25, 1994, passim; and Dan Morgan, "How Medicaid Grew," four-part series and related articles, Washington Post, January 30-February 2, 1994.

[69] Stone, p. 32.

[70] Quoted in "Report of the Disability Advisory Council on Social Security," March 11, 1988, p. 10.

[71] Quoted in ibid.

[72] Stone, p. 69.

[73] Ibid., p. 80.

[74] Ibid., p. 173.

[75] Michele Applegate, acting deputy administrator, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Testimony before the U.S. House of Representatives Committee on Ways and Means, Subcommittees on Social Security and Human Resources, February 10, 1994, p. 2.

[76] Timothy O'Brien, "A PC Revolution: Aided by Computers, Many of the Disabled Form Own Businesses," Wall Street Journal, October 8, 1993.

[77] Stone, pp. 114-32.

[78] See American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, DSM-IV (Washington: American Psychiatric Association, 1994).

[79] See General Accounting Office, "Social Security Disability: SSA Quality Assurance Improvements Can Produce More Accurate Payments," GAO/HEHS-94-107, June 1994, p. 5-6.

[80] Social Security Administration, Disability Reengineering Proposal, p. 18221.

[81] In September 1994 SSA announced a plan to make the first major changes to the disability claims process since the 1950s. The plan retains medical impairment as indispensable to a finding of disability. However, the emphasis has shifted to assessing the functional consequences of impairment. The plan calls for the research and development of "baselines of work-related functions" and "standardized functional assessment instruments" from scratch. Nonmedical sources will be consulted in the design of the new methodology. Expert systems software and "context-sensitive help screens" will be used to help determine who can and who cannot work.

[82] Social Security Administration, "Plan for a New Disability Claim Process," September 1994, p. 24.

[83] Heather MacDonald, "Welfare's Next Vietnam," City Journal (Winter 1995): 23-32.

[84] Supplemental Security Income Modernization Project, "Final Report of the Experts," August 1992, p. 190, proposing changes costing $105.5 billion in the first five years; and H.R. 2676, 103d Cong., sponsored by Rep. Carrie Meek (D- Fla.), embodying Modernization Project proposals.

[85] Public Law 103-296, August 15, 1994; and Conference Report on the Social Security Administrative Reform Act of 1994, H.R. Rep. no. 103-670, August 4, 1994. See also Spencer Rich, "Social Security Gets Ready for Independence," Washington Post, August 17, 1994.

[86] SSA estimates that 6 of 10 addicts have physical or mental impairments that may still qualify them for payments after the 36-month cutoff. John O'Donnell and Jim Haner, "Crackdown on Addicts Looks Costly," Baltimore Sun, October 13, 1994,

[87] "Many . . . drug addicts and alcoholics . . . suffer from . . . changes in brain chemistry that severely affect their functioning. . . . Many of them also have mental health problems." Applegate, p. 1.

[88] About one-fourth of the money will be drawn from the retirement trust fund; also SSA expects to spend an additional $285 million on legal challenges and paperwork. O'Donnell and Haner, "Crackdown on Addicts Looks Costly"; and John O'Donnell and Jim Haner, "Outrage Follows Report on Crackdown Costs," Baltimore Sun, October 14, 1994.

[89] Conference Report on the Social Security Administrative Reform Act of 1994, p. 137.

[90] "To Terminate the Eligibility of Children under 16 Years of Age for SSI," H.R. 3913, February 24, 1994.

[91] See, for example, Citizens against Government Waste, "Report of the Task Force on Social Security," August 1994; Peter J. Ferrara, Social Security: The Inherent Contradiction (Washington: Cato Institute, 1980); and The Cato

Handbook for Congress (Washington: Cato Institute, 1995), chap. 16, pp. 159-67.